

INSTRUCTIONS
ADVANCED PRACTICE PROFESSIONAL NURSE (APPN)
2005-2007 RENEWAL APPLICATION

- In order to renew your Advanced Practice Professional Nurse License in the category of Certified Nurse-Midwife (CNM), Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), or Registered Nurse Anesthetist (RNA), you must also renew your professional nurse (RN) license (*unless your primary state of residence is in a Compact State*). Renewal applications may be submitted together with one check or money order to cover the APPN renewal fee (\$50) and the RN renewal fee (\$50), or your RN license can be renewed on-line and your APPN submitted via paper, or either form may be submitted individually. (APPN applications are also available for download from the Board's website at www.state.id.us/ibn click on "Licensing Information".) Applications post-marked after August 31, 2005, will be assessed an additional \$35.00 late fee. Both applications must be completed and signed to avoid a delay in processing.
- If your name and/or address on the renewal application are not correct, print the correct information on the appropriate line. (Name Changes must be accompanied by copy of marriage license, divorce decree, other legal document, or Notarized Affidavit available from this office.)
- Complete questions 1 through 12. (Questions 8 and 9 are voluntary disclosure information and responses are optional.)
- Enclose a copy of your current national certification(s). If you are not currently certified, and were approved as a nurse practitioner prior to July 1, 1998 you are exempt from this requirement (IDAPA 23.01.01.300.06.)
- Complete the enclosed Continuing Education Activities Report (or provide the same information on a form of your choice). Do NOT submit copies of validation materials regarding the continuing education unless instructed to do so.
- The Criteria for APPN Continuing Education were adopted by the Board in February 1999. The criteria require that:
 - a. The provider of continuing education must be:
 - 1) a nationally recognized nursing organization; or
 - 2) an accredited academic institution; or
 - 3) a provider of continuing education recognized by another board of nursing; or
 - 4) a provider of continuing education recognized by a regulatory body of another discipline (e.g. CME, CPE, telemedicine); or
 - 5) approved by the Board of Nursing.
 - b. Content must be related to the practice of the APPN.
 - c. Acceptable CE activities will include activities identified in 'a' above and in addition, may include:
 - 1) participation as the presenter of approved continuing education programs (presenting continuing education may not be your primary job responsibility);
 - 2) participation in related professional activities including but not limited to research, published material, teaching, peer review, precepting and professional auditing. (A total of no more than three (3) contact hours may be awarded for related professional activities.)
 - d. Evidence of documentation of completion of the continuing education activity. (e.g. transcript, certificate, verification letter, etc.)

PEER REVIEW POLICY

Peer Review is:

- A process that measures on-going practice competency of the advanced practice nurse (APPN).
- Performed by a licensed APPN, Physician, PA or other professional certified by a recognized credentialing organization.
- Focused on a mutual desire for quality of care and professional growth incorporating attitudes of mutual trust and motivation.

Peer Review shall:

- Reflect nationally recognized standards of care.
- Provide evidence of competence.
- Include one or more of the following peer review processes:
 - Clinical rounds
 - On-site peer collaboration
 - Retroactive records review
 - Other appropriate processes as defined by the APPN and approved by the Board
- Provide evidence that issues identified in the peer review process have been/are being appropriately addressed.

Completion of a peer review process will be evidenced by:

- Signature of the attestation statement at the time of biennial licensure renewal.
- APPN supporting documentation at the request of the Board, e.g., signed peer statement, reports/records, peer contract, institutional policy, etc.
- Demonstration/documentation available at on-site practice audit.

Adopted November 11, 2004

➤ **Affix your signature to the application.**

APPN # _____

RN #: _____

IDAHO BOARD OF NURSING

PO Box 83720 ♦ Boise, Idaho 83720-0061 ♦ (208) 334-3110 ext. 25

**RENEWAL APPLICATION
ADVANCED PRACTICE PROFESSIONAL NURSE (APPN)**

Print: _____
 Name: _____
 Mailing Address: _____

For office use only	
Certificate No.	_____
Check <input type="checkbox"/>	Cash/MO <input type="checkbox"/>
Date Rec'd	_____
RN License Issued	_____
Approval	_____
Date Issued	_____

Mail completed application with the \$50.00 fee to the Board of Nursing by August 31, 2005. (Applications accompanied by personal checks will be held for ten (10) days to allow for processing of the check by the bank.) The amount due will be \$85.00 if the application is post-marked after August 31, 2005. In order to renew your Advanced Practice Professional Nurse License, you must also renew your professional nurse (RN) license (unless residing in Compact state). Applications will be returned if incomplete or the incorrect fee is submitted.

Indicate changes in name and/or address:

(Name Changes must be accompanied by marriage license, divorce decree, other legal document, or Notarized Affidavit available from this office.)

- Category of Licensure:

<input type="checkbox"/> Certified Nurse-Midwife	<input type="checkbox"/> Clinical Nurse Specialist
<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Registered Nurse Anesthetist
- I am practicing as an APPN: ☐ Full-time ☐ Part-time, or I am: ☐ Not Practicing
- I am practicing: ☐ In-State ☐ Out-of-State
- Primary Practice Setting:

<input type="checkbox"/> Health Care Institution (hospital, nursing home, etc.)
<input type="checkbox"/> Government outpatient clinic
<input type="checkbox"/> Private outpatient clinic
<input type="checkbox"/> Physician-owned practice
<input type="checkbox"/> Non-physician-owned practice
<input type="checkbox"/> Other (specify) _____
- Specialty Areas of APPN Practice: (mark all that apply):

<input type="checkbox"/> Acute Care	<input type="checkbox"/> Adult Care	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Family Practice	<input type="checkbox"/> Gerontology
<input type="checkbox"/> Midwifery	<input type="checkbox"/> Neonatology	<input type="checkbox"/> Oncology	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Psych/Mental Health
<input type="checkbox"/> School Nsg	<input type="checkbox"/> Women's Hlth	<input type="checkbox"/> Critical Care/CCU	<input type="checkbox"/> Other (specify) _____	

Continued on reverse

continued...

6. I currently prescribe: ☐ legend drugs ☐ scheduled drugs
7. I currently dispense: ☐ legend drugs ☐ scheduled drugs
8. *Gender: ☐ Female ☐ Male
9. *Ethnicity: ☐ Caucasian ☐ African American/Black
☐ Hispanic ☐ American Indian/Alaska Native
☐ Asian/Pacific Islander ☐ Multi-Racial
☐ Other _____

*Voluntary disclosure information – response optional

10. Please [X] the appropriate box(es) pertinent to your practice:

☐ I have completed thirty (30) contact hours of continuing education that meet Board established criteria during the renewal period.

☐ I have completed ten (10) contact hours of approved pharmacology-related continuing education during the renewal period.

☐ I have practiced a minimum of two hundred (200) hours of advanced practice professional nursing during the renewal period.

11. **CNM, CNS, NP only:**

☐ I have participated in a Peer Review process that meets Board-established criteria.

12. I have attached a copy of my current APPN national certification(s):

☐ Yes

☐ No - Please explain below:

My signature affixed below attests that the information provided in this application for renewal of my advanced practice professional nurse licensure is true and correct to the best of my knowledge.

Signature _____

Date _____

ATTENTION: CERTIFIED REGISTERED NURSE ANESTHETISTS

Administrative rules of the Board (IDAPA 23.01.01.300.03) indicate that licensure renewal is dependent on, among other things, “documentation of thirty (30) contact hours of continuing education during the renewal period”. The rules indicate further that continuing education may be that required for renewal of national certification if documentation is submitted confirming the certifying organization’s requirement is for at least thirty (30) contact hours.

The Board is aware that the AANA requires completion of more than the required number of hours every two years for certification renewal, and that the renewal cycle may be calculated on either an even- or odd-numbered year biennial cycle. The Board agrees that the AANA’s requirement for certification renewal is consistent with the administrative rule. **Therefore, submission of a copy of your current AANA certificate is sufficient evidence to meet this requirement. On the “Continuing Education Activities Form”, indicate your name, APPN license number and the expiration date of your AANA certification only. It is not necessary to complete the form as indicated.**

Please note: If you are selected for a random audit, you will be required to submit documentation (transcripts, certificate, etc.) that verify completion of continuing education during the AANA renewal cycle.

IDAHO CODE 54-1411 (2) does not require the process of Peer Review for Registered Nurse Anesthetists.

**IDAHO BOARD OF NURSING
ADVANCED PRACTICE PROFESSIONAL NURSE
CONTINUING EDUCATION ACTIVITIES REPORT**

FROM 9/2003 TO 8/2005

NAME _____
IDAHO APPN License number: CNM _____ CNS _____ NP _____ RNA _____
ADDRESS _____

**Advanced Practice
Professional Nurse
License Renewal:**

Rule 23.01.01.300.03.

RENEWAL OF LICENSURE IS DEPENDENT UPON documentation of 30 contact hours of continuing education during... [the last] two year period

Authorization Renewal:
Rule 23.01.01.315.02.b.

RENEWAL OF PRESCRIPTIVE AUTHORITY IS DEPENDENT UPON completion of ten (10) contact hours of approved pharmacology-related continuing education in the twenty-four (24) months immediately preceding application for renewal. Hours may be part of the thirty (30) required hours (above).

DEFINITIONS:

CONTINUING EDUCATION_- consists of planned learning experiences designed to maintain and update knowledge, skills, and attitudes for the enhancement of practice.
CONTACT HOURS = equal clock hours.

THIS REPORT MAY BE AUDITED. IF SELECTED FOR AUDIT, YOU MAY BE ASKED TO SUBMIT DOCUMENTATION OF COMPLETION OF INDICATED CONTINUING EDUCATION. (Attach additional pages if necessary.)

DATE	NAME OF PROGRAM	SPONSOR	Contact Hours	Pharmacolgy-Related Hours

Idaho Board of Nursing
APPN AUDIT
Phase I

Please complete the following form as part of your renewal application and return with your completed application in the envelope provided.

Name: _____
APPN License Number: _____
Primary County Where You Work: _____
List Your National Specialty Certification(s): _____

1. IDAPA 23.01.01.280.02.a. & b.; 03.; 04.; 05.; & 06.

- Which of the following describes your relationship(s) with the physician(s) with whom you work? *(Please check all that apply.)*

_____ I collaborate daily with physician(s) on site.
_____ I contact various physicians by specialty for collaboration, as needed.
_____ I can call for advice PRN.
_____ Physician does in-house chart reviews.
_____ I call physician(s) at least one time per week.
_____ I have a signed contract with a physician(s), which defines the relationship.

2. IDAPA 23.01.01.280.02.a & b.; 03.; .04.; .05.; & .06.

- Check the setting which describes where you practice the majority of time:

_____ Hospital
_____ Clinic, For example: Emergent Care, Specialty (diabetes, rehab, etc.)
_____ Public or Private Educational Institution
_____ Public Health, For example: STD/Family Planning, Immunizations, Education (wellness, cardiac rehab, etc.)
_____ Home Care
_____ Physician Office
_____ Long Term Care Facility
_____ Other, specify: _____

3. IDAPA 23.01.01.280.02.a. & b.

- Which practitioners have you collaborated with in the past year? *(Please check all that apply.)*

_____ Physician	_____ Physical Therapist
_____ Occupational Therapist	_____ Speech Therapist
_____ Dietitian	_____ Social Worker
_____ Counselor	_____ APPN
_____ Pharmacist	_____ Other, specify: _____

4. IDAPA 23.01.01.280.02a. & b.

Are there other health care providers in your practice setting?

Yes _____ No _____

If yes - I have collaborative relationships with the following health care providers:

☐ APPN ☐ MD ☐ PA ☐ RPh ☐ Other _____

5. IDAPA 23.01.01.315.01.c., .315.06.; 316.01., & 316.03.

- Which of the following do you prescribe? *(Please check all that apply.)*

_____ Legend Medications
_____ Controlled Substances
_____ Other, specify _____
_____ None

OVER

6. IDAPA 23.01.01.315.05.a, b.; 315.06.; 316.01.; 316.03.; & 316.04.

- Including samples, which of the following medications do you dispense?

(Please check all that apply.)

_____ Legend Medications

_____ Controlled Substances, Schedule:

_____ II _____ III _____ IV _____ V

7.

- Indicate the Percentage (%) of clients on the following reimbursement programs:

_____ Medicare _____ Medicaid _____ Private Insurance _____ Other _____ Uninsured

8. IDAPA 23.01.01.280.07. & 300.03

- Which mechanisms do you use to assess your continued competence? *(Please check all that apply.)*

_____ Peer Review _____ Continuing Education _____ Current Specialty Certification

_____ Other, specify: _____